I. INTRODUCTION

A. RESPONSE TEAMS DESCRIPTION MANUAL 1
B. BACKGROUND 2
C. DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) MISSION AND SCOPE 3
D. NDMS DEVELOPMENT 4
E. NDMS CONCEPT AND DESIGN 5
F. RESPONSIBILITIES WITHIN NDMS 7
G. MANUAL OBJECTIVES 8

I. INTRODUCTION

A. RESPONSE TEAMS DESCRIPTION MANUAL

The Response Teams Description Manual documents the organization and position requirements for four primary National Disaster Medical System (NDMS) Medical Response Teams. These Teams are the Disaster Medical Assistance Team (DMAT), Disaster Mortuary Operational Response Team (DMORT), Veterinary Medical Assistance Team (VMAT), and National Medical Response Team/Weapons of Mass Destruction (NMRT/WMD). These Teams collectively comprise the medical response component of NDMS and assist NDMS in fulfilling its responsibilities. The Department of Health and Human Services (HHS) activates these Teams as needed in response to requests for assistance.

The NDMS, through the Department of Health and Human Services, Office of the Secretary, Office of Public Health Science, Office of Emergency Preparedness (HHS/OS/OPHS/OEP, hereafter referred to as OEP), fosters the development of these Medical Response Teams. DMATs are capable of providing large-scale medical or specialty care such as crush injury, burn, and mental health emergencies. DMORTs provide mortuary services while VMATs are designed to provide veterinary services. NMRT/WMDs are equipped and trained to provide initial medical care for victims of weapons of mass destruction.

This Manual describes the following for each of the four medical Teams listed:

Team description and capabilities;
Organizational structure;
General requirements;
Training requirements;
Position descriptions;
Operational checklists for mission deployments; and
Equipment guidelines and cache list.

I. INTRODUCTION

B. BACKGROUND

Great disasters are not uncommon throughout the world. Included in these are the 1984 Bhopal, India, toxic gas release, the 1988 Armenian earthquake, the 1991 eruption of Mt. Pinatubo, and the 1971 ship explosion in Halifax, Nova Scotia. While these have all occurred outside of the U.S., each of these disasters has an American analogue: the 1989 Loma Prieta earthquake; the eruption of Mt. St. Helens in 1980; explosions in Port Chicago, California in 1994; Texas City, Texas, in 1947; and the Oklahoma City bombing in 1995. Adding to the list of major disasters are massive Mid-West Flooding in 1993 and several large and powerful weather events, such as Hurricanes Hugo in 1989, Andrew in 1993 and Marilyn in 1996. Fortunately, each of these events resulted in a limited number of casualties. Similar incidents will occur in the future, however, possibly with more deadly results. As American cities increase in area and population, a significant mass casualty incident becomes more likely and mandates the nation to maintain a continual readiness and capability to handle a range of disastrous events.

Of natural disasters, earthquakes are the most serious threat. A great earthquake is most likely in California or the New Madrid area of the Mid-West, although the East Coast cannot be totally excluded. Such an event near Los Angeles may cause 20,000 deaths and 100,000 major injuries. Volcanic eruptions are also a significant potential threat. Eruption of any of several dormant Cascade volcanoes might threaten inhabited areas in Washington, Oregon, or California. Other natural disasters like hurricanes, tornadoes, and floods occur more frequently in the United States. Fortunately, they are less likely to cause catastrophic numbers of injuries, but they may still require special medical aid for victims.

In modern times, technologic disasters have also become a threat. Into this class fall accidents due to human inventions. Such incidents include explosions, releases of toxic substances, transport accidents, dam failures, and a myriad of other mishaps. Small size technologic accidents happen every day. Significant size events happen infrequently, but it is clear that massive casualties might readily occur. Most major American cities with large chemical industries or transport nodes are at risk of industrial explosions such as occurred in Halifax, Port Chicago, or Texas City. The toxic chemical incidents that occurred in Bhopal, India, and in Seveso, Italy, demonstrate what the consequences might entail. The 1986 Chernobyl incident in the Ukraine demonstrated the possible consequences of a nuclear reactor accident. This nation must be prepared to deal with like circumstances.

I. INTRODUCTION

B. BACKGROUND

Finally, because it is almost impossible to completely thwart terrorist activity, all areas of the country must be prepared to handle a large-scale, mass casualty incident that could involve conventional explosives, either separately or in conjunction with nuclear, biological, or chemical agents (NBC).

It is due of the potential for these large-scale disasters that HHS developed the capability of emergency response to disasters.

C. DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) MISSION AND SCOPE

HHS provided health and medical services may be activated during times of disasters and emergencies under the Stafford Act, which activates the Federal Response Plan (FRP); the Federal Family Assistance Plan for Aviation Disasters; Presidential Decision Directive 39 (PPD-39), which activates the Health and Medical Services Support Plan for the Federal Response to Acts of Chemical/Biological Terrorism; the Immigration Emergency Plan; and the Memorandum of Understanding (MOU) between HHS and the Department of Defense (DoD). More information is available on HHS activations in the HHS Health and Medical Response System Operations Description Manual.

Included in the HHS response is overall public health response; the triage, treatment, and transportation of victims of the disaster; and the evacuation of patients out of the disaster area into a network of hospitals located in the major metropolitan areas of the U.S. HHS, through OEP, assists State and local governments affected by disasters or other major events by utilizing resources from the following sources:

+ The Administration for Children and Families, Health Care Financing Administration, and Administration on Aging;
+ NDMS;
+ Specific non-Federal sources such as major pharmaceutical suppliers, hospital supply vendors, and international disaster response organizations; and
+ Other supporting Federal departments and agencies.

Of these, the resources provided through the NDMS are designed to respond directly to the disaster site and provide a high level of health and medical care under often times austere conditions.

I. INTRODUCTION

D. NDMS DEVELOPMENT

The U.S. is amply provided with health care personnel and hospital beds. However, health care assets are proportioned to normal demands for health care. A disaster may cause a sudden “surge” of casualties far in excess of the usual heath care demand. The additional demand, moreover, is principally comprised of trauma victims, who require more services than everyday patients with illnesses of a predominately medical nature.

The typical American metropolitan area today has an emergency medical services (EMS) system and several medical centers specializing in trauma services. An EMS system typically anticipates about 100-200 emergency cases daily per million population. The trauma system might normally handle about 5-10 serious trauma cases per day. Both EMS and trauma systems have substantial reserve capacity and can usually handle two to three times their average workload when multiple casualty incidents occur. In most areas, EMS services can be augmented by mutual aid from nearby areas, which can provide additional ambulances and staff when local response capability is strained. This capability is typically scaled for foreseeable multiple casualty incidents of 20 to 100 victims. They are seldom scaled for large disasters.

A disaster is considered an incident in which the magnitude or severity exceeds the response capability of the affected area. The disasters that have struck American cities in recent memory have fortunately not caused massive morbidity or mortality. Because of the relatively few disasters that have caused substantial injuries, the health care systems of American cities have not been recently challenged. However, most metropolitan areas or States lack capability to deal with a disaster-caused surge of casualties. A disaster may easily create morbidity rates of one per thousand among the population exposed to it. The 100,000-casuality estimate for the predicted "Great California Earthquake" represents a morbidity of 10 per thousand. It is clearly beyond the capability of any American metropolitan area to respond adequately to the causalities of such events, especially since most would occur at the same time and require simultaneous treatment.

I. INTRODUCTION

D. NDMS DEVELOPMENT

In 1981, the President established the Emergency Mobilization Preparedness Board (EMPB) to develop national policy and programs to improve emergency preparedness. The EMPB delegated health program development to the Principal Working Group on Health (PWGH) and included representatives from all Federal agencies concerned with health care. From this group came the NDMS concept and design. Today, an NDMS Senior Policy Group (SPG) made up of HHS, DoD, the Department of Veterans Affairs (VA), and the Federal Emergency Management Agency (FEMA), with HHS as the administrative lead agency, provides leadership and overall policy and program goals for the NDMS. The NDMS has evolved into a major component of disaster medical care.

E. NDMS CONCEPT AND DESIGN

The U.S. EMS system is among the very best in the world. Nevertheless, no U.S. city is adequately prepared to deal with catastrophic casualties. Any area of the nation would require outside support to provide appropriate medical care to victims of such incidents. In order to cope with very large incidents, this support must be national in scope and must be able to handle surges as large as those estimated in the worst case scenario. A system for dealing with disaster casualties must therefore provide for external aid. A nationwide system of medical mutual aid is the most effective method to provide outside support. The NDMS serves as this nationwide mutual aid system.

The NDMS concept was conceived to fulfill three main objectives:

Medical response - under the lead of HHS, to a disaster area in the form of a Management Support Team (MST), health and Medical Response Teams, and medical supplies and equipment;

Evacuation of patients - under the lead of DoD, for patients that cannot be cared for locally to designated locations throughout the U.S.; and

Hospitalization of evacuated patients - under the co-lead of the VA and DoD, in a nationwide, voluntary network of non-Federal NDMS participating medical facilities.

I. INTRODUCTION

E. NDMS CONCEPT AND DESIGN

The system is designed to care for as many as 110,000 victims of any incident that exceeds the medical care capability of the affected State, Region, or Federal medical care system. NDMS may be activated under the FRP and other agreements and used in a variety of national emergency events, such an earthquake, hurricane, major flooding or man-made catastrophic disasters. NDMS may also be activated in the absence of a Federally-designated disaster by the Assistant Secretary of Health (ASH) upon request of a State Health Officer in situations not involving a Presidential declaration. These situation may include industrial accidents, refugee influx, NBC acts of terrorism, or major transportation accidents. In the event of a military contingency, the Assistant Secretary of Defense (Health Affairs) would have authority of activate NDMS.

NDMS provides the planning and operating structure to meet the requirements of the medical assistance component, drawing upon the resources of the partners and/or the voluntary community-based organizations that provide specialized medical teams. NDMS, and the individual partner agency assets, fulfill a minimum of 6 of the most resource intensive, critical functions required to assist in meeting the health and medical needs resulting from an emergency or major disaster. These six critical functions are:

Assessment of health/medical needs;
Medical care personnel;
Health/medical equipment and supplies;
Victim identification/mortuary services;
Patient evacuation; and
In-hospital care.

The first four of these critical functions are assisted or provided by the development and deployment to disasters of DMAT, DMORT, VMAT, and NMRT/WMD Medical Response Teams.

I. INTRODUCTION

F. RESPONSIBILITIES WITHIN NDMS

Each response Team has one or more sponsoring organizations. Examples of agencies sponsoring health and medical Teams are licensed hospitals and major medical centers, public heath and safety agencies, and non-profit organizations capable of providing disaster health services. Sponsorship is accomplished through a MOU with OEP.

The sponsoring organization is responsible for:

Organizing and maintaining a disaster Medical Response Team;
Recruiting and selecting qualified members;
Training Team members on basic NDMS orientation, position duties and responsibilities, and duties and responsibilities of other health and medical participants in disaster relief operations (the sponsoring organization must also develop and conduct regular exercise sessions for the entire Team);
Obtaining and maintaining disaster medical equipment;
Providing medical supplies for immediate response to local disasters; and
Mobilizing the Team for response to local incidents or NDMS activated Federal disaster events.

OEP is responsible for:

Providing guidance on the organization and composition of the Team;
Providing training materials and practical guidance in disaster medical skills;
Providing personnel to assist in the administration and management of the Team; and
Assisting in the location and acquisition of supplies and equipment from Federal and/or local donor sources.

Once the Team has been activated for a Federal NDMS response, OEP will:

Appoint Team members to appropriate Federal status;
Provide transportation, food, supplies, shelter, and logistical support to resupply the Team after the first 72-hours.
Compensate Team members for Federal service and expenses during the performance of their assigned tasks; and
Return the Team members to their home jurisdiction after conclusion of the event.

I. INTRODUCTION

F. RESPONSIBILITIES WITHIN NDMS

Teams are required to maintain a roster of qualified personnel to ensure full Team deployment, preferably three people deep at each position. Team management is responsible for ensuring that all members meet the NDMS basic requirements as specified in the NDMS Personnel Administrative Handbook, Team General Requirements, and the Knowledge, Skills, and Abilities (KSA) of the appropriate position. Qualified Team members must be pre-enrolled in the NDMS personnel system. This system allows for the rapid appointment of Team members as temporary Federal employees during an NDMS activation. The appointment to Federal status facilitates Team members' movement across State lines and allows them to provide medical care without regard to the licensure/certification requirements of the State in which they are working. It provides Team members with protection from malpractice and liability exposure under the Federal Tort Claims Act. It also allows for a system to compensate members for their period of Federal service during an NDMS activation and response as well as affording the members Workman's Compensation and other Federal employment benefits.

G. MANUAL OBJECTIVES

The material presented in this Manual provides a formal method to document the duties, responsibilities, and requirements of each position on NDMS
Health and Medical Teams. This provides a minimum standard to ensure all positions are filled by qualified personnel. All information in the position descriptions and operational checklists are based on a generic mission assignment and may be necessarily adjusted or added to depending on the specific requirements of the assignment.

The Team organizational structures represent standard deployments for the applicable Team and are designed within conceptual principles of the National Interagency Incident Management System (NIIMS)/Incident Command System (ICS), hereafter referred as ICS. NIIMS ICS is a nationally recognized system that provides a total systems approach to all-risk incident management and has been adopted by many response agencies. This system is the model for the organization and operations of NDMS health and medical resources.

I. INTRODUCTION

G. MANUAL OBJECTIVES

ICS principles ensure proper incident action planning, unity and chain of command, span of control, personnel accountably, resource sharing, and common terminology among Teams and local response efforts. This standardizes the organization and operations of all Teams while on a deployment and provides an accepted emergency management system with the flexibility and adaptability to a variety of incidents. This allows all Teams to understand the capabilities and operations of other Teams and local emergency responders in relation to their Team mission and objectives, and allows an integrated response effort. Additional positions can be added to each Team at the discretion of OEP in order to provide more specialized medical care.

The position duties and requirements in this Manual also serve to document a pathway for individuals seeking to become qualified to serve in one or more of the Team positions. From this Manual, an individual can determine all requirements necessary to qualify for any position and in turn, determine the best method of obtaining the necessary knowledge and experience.